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PROTECTING TOMORROW'S INSURABILITY TODAY

Application for Assured Access

MEDAVIE BLUE CROSS™

644 Main Street | 230 Brownlow Avenue Dartmouth
Moncton NB E1C 8L3 | PO Box 2200 Halifax NS B3J 3C6
Tel.: 1-800-667-4511 Fax: 506-867-4651

If you have any questions about Assured Access or Elements, or need assistance completing the application form, please contact your Medavie Blue Cross authorized agent or sales professional today.

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PROTECTING TOMORROW'S INSURABILITY TODAY

How would you cover health-care costs if you lost your group health benefits?

Routine expenses can add up quickly. Without health coverage, all routine and non-routine health care costs not eligible under a provincial health care plan come out of your pocket, and the cost can be shocking. Make the Assured Access plan from Medavie Blue Cross an important component of your financial planning process and ensure your savings are not depleted by health care costs.

WHAT IS *ASSURED ACCESS*?

Assured Access ensures that your future insurability is secured based on your health today. As we age our health often deteriorates, making it difficult to be approved for health care coverage. With Assured Access you don't have to worry about qualifying for health coverage later in life.

If you lose your group health benefits due to retirement, career change, employment cutbacks, business closure or a disability, Assured Access allows you to stay covered.

Assured Access also allows you to add Critical Illness, Travel, Hospital Cash and/or Dental modules.

ASSURED ACCESS BENEFITS

Within 60 days of losing your group health benefits, you will be eligible to enrol in a Medavie Blue Cross personal health plan. This plan provides comprehensive health and drug benefits and the Assured Access module.

While your group coverage is in force, Assured Access also protects you and your family by offering you an additional $10,000 of Accidental Death and Dismemberment coverage.

Assured access also offers a wellness program. InConfidence provides 24 hour counselling and online resources to help you manage everyday issues relating to family, work, health and money.

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elements
by Medavie Blue Cross

ELEMENTS PERSONAL HEALTH PLAN BENEFITS:

What are my choices?

HEALTH BENEFITS REQUIRED	Entry: Health	Essential: Health	Enhanced: Health
DRUG BENEFITS OPTIONAL	Essential: Drug	Enhanced: Drug	
DENTAL BENEFITS OPTIONAL	Entry: Dental	Essential: Dental	Enhanced: Dental
ADDITIONAL MODULES OPTIONAL	Critical Illness	Hospital Cash	Assured Access

Pick and choose your own customized plan to suit your needs.

EXAMPLE: Essential: Health + Enhanced: Drug + Entry: Dental + Assured Access = Right for me!

If you become eligible again for group health coverage while enrolled in the personal health plan, you may return to the ***Assured Access*** plan and place your personal health coverage on hold. As long as the ***Assured Access*** module is kept active, you can switch between your personal health plan and your ***Assured Access*** plan as many times as you experience a loss of group benefits.

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Assured Access Eligibility Check List

All individuals to be covered under the policy:

- ☐ Must be age 64 or under on the effective date of coverage; and
- ☐ Must currently have group health coverage.

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APPLICANT INFORMATION

Last Name _____ First Name _____ Language Preference ◉ English ○ French

Address

_____ _____ _____ _____
Street and Number City/Town Province Postal Code

Telephone Numbers and E-mail

_____ _____ _____ _____
(Home) (Work) (Cell) E-mail Address

Occupation

_____

How long have you been continuously employed? _____ Years _____ Months

Your policy will be issued by email.

Are you a seasonal worker? ○ Yes ◉ No

All individuals applying for coverage under this application must have Group health benefits

Please specify below

Name of employer providing Group Health Benefits _____

Effective Date of Group Health Benefits _____

ID # _____ Policy # _____

Would you like to add the following modules? Please select from the following:

☐ Critical Illness ☐ Hospital Cash ☐ Travel ☐ Entry Dental ☐ Essential Dental ☐ Enhanced Dental

EFFECTIVE DATE OF POLICY

Requested Effective Date of Policy: Please begin my coverage on the 1st day of (month/year): _____

The *Assured Access* rates that are in effect as of the policy effective date shall apply to this application.

* Group Health Benefits – an employer-sponsored health benefit plan consisting of three or more employees.

Please list all individuals to be covered under this ***Assured Access*** plan.
For any individual between the ages of 21 and 26, please indicate who is a full-time student.

First Name	Last Name	Sex M/F	Date of Birth DD MM YY	Full-Time Student?	Height	Weight	Smoker?	Pregnant?	Pregnancy Due Date DD MM YY
Applicant		00					○ Yes ○ No	○ Yes ○ No	
Spouse**		01					○ Yes ○ No	○ Yes ○ No	
Child		02							
Child		03							
Child		04							
Child		05							

All individuals to be covered under the *Assured Access* policy must be age 64 or under on the effective date of coverage.

** Spouse shall mean an individual who is married to the applicant, or in a conjugal relationship for at least one year or resides at the same address as the applicant.

FOR INTERNAL USE ONLY

Identification Number _____ Cash Office: Amount Received _____ ○ Agent ○ Branch ○ Client

PART TWO: **MEDICAL INFORMATION** - Please answer the following medical questions for all individuals.

1. Are you and all listed dependents currently covered by a Provincial Health Plan in Atlantic Canada (Medicare in New Brunswick, Medical Services Insurance (MSI) in Nova Scotia, Hospital and Medical Services Ins. in Prince Edward Island or Medical Care Plan (MCP) in Newfoundland)? ○Yes ○No

   If no, please explain: _____

2. Has any individual to be covered ever consulted a physician, been treated for or had any indication of:

A. High blood pressure, stroke, heart attack, heart disease, chest pain or angina? ○Yes ○No
B. Asthma, allergies or other breathing problems? ○Yes ○No
C. Back, neck or knee pain, muscle or joint pain, arthritis or injury? ○Yes ○No
D. Stomach, intestinal, liver or kidney disorder? ○Yes ○No
E. Alcohol or drug dependency? ○Yes ○No
F. AIDS or HIV infection? ○Yes ○No
G. Recurrent infections or elevated cholesterol? ○Yes ○No
H. Diabetes, colitis, Crohn's, acne/rosacea/cold sores or skin disease/disorder or osteoporosis? ○Yes ○No
I. Depression, anxiety or other mental illness, insomnia or other sleep disorder? ○Yes ○No
J. Disease or disorder of the reproductive system or infertility or hormone/menopausal symptoms? ○Yes ○No
K. Cancer or leukemia? ○Yes ○No
L. Chronic headaches, epilepsy or multiple sclerosis? ○Yes ○No
M. Within the last two years, has any individual to be covered been hospitalized ○Yes ○No

3. Within the last two years, has any individual to be covered required:

A. The services of a chiropractor, physiotherapist, psychologist or podiatrist, naturopath, acupuncturist, massage therapist, athletic therapy or social worker? ○Yes ○No
B. Ostomy supplies, diabetic supplies, maximist, CPAP or TENS machine? ○Yes ○No
C. Orthopedic shoes, orthopedic supplies or arch supports? ○Yes ○No
D. Ambulance services or nursing care? ○Yes ○No
E. Artificial limbs/prosthesis, braces, walker, wheelchair or oxygen? ○Yes ○No

PLEASE PROVIDE DETAILS TO ALL YES ANSWERS TO QUESTION #2 AND QUESTION #3

Individual's Name	Condition	Type and Number of Treatments	Date First Treated	Date Last Treated	Results of Treatment/ Extent of Recovery

4. Does any individual to be covered take prescription medication or have a prescription for which refills are currently authorized? (Include all forms of medication - pills, patches, injections, drops, creams and suppositories.) ○Yes ○No If you answered yes, please provide details.

Individual's Name	Prescription Name	Reason for Medication	Strength of Medication	Quantity Taken

5. Does any individual to be covered currently have a referral, testing, treatment, investigation, surgery or appointment contemplated or completed but for which the results have not yet been received? ○Yes ○No
   If you answered "yes", please provide Individual's Name, Condition, Date of Appointments and other pertinent information.

6. Does any individual to be covered have a physical or mental impairment, disease or disorder not stated in the preceding? ○Yes ○No
   If you answered yes, please provide Individual's Name, Condition, Type of Treatment etc.

7. During the past three years, have you or any listed dependent had your driver's licence suspended or revoked or been convicted of:
   a) more than three driving violations? **b)** refusing to take a breathalyzer? or **c)** driving while impaired ○Yes ○No If you answered yes, please give details:

PART TWO: **MEDICAL INFORMATION** (CONT'D) - Please answer the following medical questions for all individuals.

8. In the past five years, have you or any listed dependent ever used narcotics (e.g. morphine, heroin), controlled substances (e.g. diazepam, lorazepam), hallucinogens (e.g. LSD, marijuana) or stimulants (e.g. amphetamines, cocaine), except as prescribed by a physician? ◯ Yes ◯ No If you answered yes, please give details:

Individual's Name	Type	Usual Quantity	Frequency of Use	Date of last usage

PART THREE: **AGREEMENTS**

AGREEMENT AND CONSENT

I/We, the undersigned, understand and agree that any pre-existing condition/injury or the signs of which that appeared or occurred on or before the date of this application are not covered by the personal health plan that can be accessed through this policy. The discovery of facts known by my/our eligible dependents or me/us but not stated on this application could result in the denial of a claim and the cancellation or modification of this policy and the personal health plan that can be accessed through this policy. I/We further acknowledge that it is my/our responsibility to notify Medavie Blue Cross of any changes in my/our health status or the health of my/our dependents from the date of application until a policy is issued or the effective date, whichever is later. Medavie Blue Cross reserves the right to recover any monies paid on my/our behalf or on behalf of my/our eligible dependents as a result of an incomplete statement, misrepresentation or omission on this application form. I/We agree to repay to Medavie Blue Cross any and all monies paid as a result of the discovery of facts not fully disclosed on this application.

I/We, the undersigned, declare the answers to the above questions are complete and accurate and form part of an application for coverage with Blue Cross Life Insurance Company of Canada (Blue Cross Life) and/or Medavie Blue Cross. The information provided herein and collected in the future as part of the application process will be kept confidential and secure. This information will be used to determine eligibility for coverage, to administer the terms of my/our policy, to recommend suitable products and services to me/us and to manage the Company's business. I/We authorize any physician, health practitioner, hospital, clinic, pharmacy, or other medical or medically-related facility, insurance company, government or regulatory authority, institute, organization or person that has any records or knowledge of me/us or my/our health, to give Blue Cross Life, Medavie Blue Cross or their reinsurer any such information. I/We further authorize Blue Cross Life and Medavie Blue Cross to disclose this information to each other, their reinsurer or to any third party when required to determine eligibility of the application. Medical information may also be released to my/our personal physician or other medical practitioner.

I/We acknowledge and agree that there is no coverage and that Medavie Blue Cross is not at risk unless a contract comes into effect as a result of this application.

This consent is valid for as long as the contract is in force, unless I/we revoke it in writing. I/We understand I/we may revoke my/our consent at any time; however, if consent is withheld or revoked the coverage may be denied or rescinded. I/We understand why my/our personal information is needed and am/are aware of the risks and benefits of consenting or refusing to consent. I/We can contact Medavie Blue Cross at 1-800-667-4511 should I/we have questions as to the collection, use or disclosure of my/our personal information.

This consent complies with federal and provincial privacy laws. *(A photographic copy of this authorization shall be as valid as the original.)*

Dated on this _____ day of _____ year _____

_____ _____

Signature of Applicant | Signature of Spouse / Cohabitant *(as previously defined)*

Please complete the Pre-authorized Debit (PAD) plan agreement below.

Name of Payor: _____ Telephone Number: _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

BANK ACCOUNT INFORMATION - PLEASE PRINT

Or attach a void cheque.

Financial Institution (FI): _____ Telephone Number: _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

FI Transit Number: |_|_|_|_|_| |_|_|_| (branch - 5 digits; FI - 3 digits) FI Account Number: |_|_|_|_|_|_|_|_|_|_|_|_|

Type of Service: ◯ Personal ◯ Business

I/We authorize Medavie Blue Cross and the financial institution designated (or any other financial institution I/we may authorize at any time) to begin deductions as per my/our instructions for recurring payments and/or one-time payments, from time to time, for payment of insurance premiums. Regular monthly payments will be debited to my/our specified account on the first business day of every month. Medavie Blue Cross will not provide monthly pre-notification but will provide 30 days notice if the deduction is subject to change. Medavie Blue Cross will obtain my/our authorization for any other one-time or sporadic debits. Medavie Blue Cross requires written notification of any changes to banking information.

This authority is to remain in effect until Medavie Blue Cross has received written notification from me/us of its change or termination. This notification must be received at least thirty (30) business days before the next debit is scheduled. This notification must be sent to the Administration Department of Medavie Blue Cross. I/We may obtain a sample cancellation form or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.cdnpay.ca.

I/We have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a reimbursement claim, or for more information on my/our recourse rights, I/we may contact my/our financial institution or visit www.cdnpay.ca.

Date: _____ Signature(s) of Bank Account holder(s): _____

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QUOTATION WORK SHEET

	Monthly Rates	NOTES
☐ Assured Access		
☐ Critical Illness		
☐ Hospital Cash		
☐ Travel		
☐ Entry Dental		
☐ Essential Dental		
☐ Enhanced Dental		
MONTHLY TOTAL		

AGENT INFORMATION (If applicable)

I hereby certify that, as an agent for Medavie Blue Cross, I have informed the applicant of the importance of making full and accurate disclosure of the matters covered in this application and that any misrepresentations or omissions may give Medavie Blue Cross the right to cancel the contract of insurance and refuse coverage under the policy. I have disclosed the company or companies I represent and any conflicts of interest they may have with respect to this transaction and that I may receive a salary, commissions or other forms of compensation for the sale of insurance company products.

Agent's Signature	Agent's Number	Agent's Tel. Number	Agent's Fax Number
	5861	902-893-0508	902-893-6126

Agent's Name (please print)	Agent's E-mail Address
Kirby Hingley-Veal	khingley@mmhi.ca

Agent's Mailing Address

Agent's Comments

TEN DAY RIGHT TO EXAMINE POLICY

You have 10 days from the receipt of the policy to examine and return it for a full refund of monies paid, if you are not entirely satisfied.

Accidental death and dismemberment benefits will be underwritten by Blue Cross Life Insurance Company of Canada.
All other benefits will be underwritten by Medavie Inc., operating under the business name Medavie Blue Cross.

QUESTIONS?

Should you have any questions about this plan or the application itself, please contact your Medavie Blue Cross authorized agent or sales professional.

FORM-347E 05/21